



New Hampshire State Health Care Innovation Model: Stakeholder Session

December 11, 2012

Meeting Agenda

Welcome & Introductions

1:30pm – 1:35pm

State Health Care Innovation Model Proposal Update

1:35pm – 1:40pm

Summary Small Group Visioning Exercise and Next Steps

1:40pm – 1:50pm

Role of Workgroups in the Model Design Process

1:50pm – 2:20pm

Review of Current LTSS programs

2:20pm – 3:25pm

Wrap-up & Next Steps

3:25pm – 3:30pm

Summary of Small Group Visioning Session

Values and Outcomes

•Delivery System Values

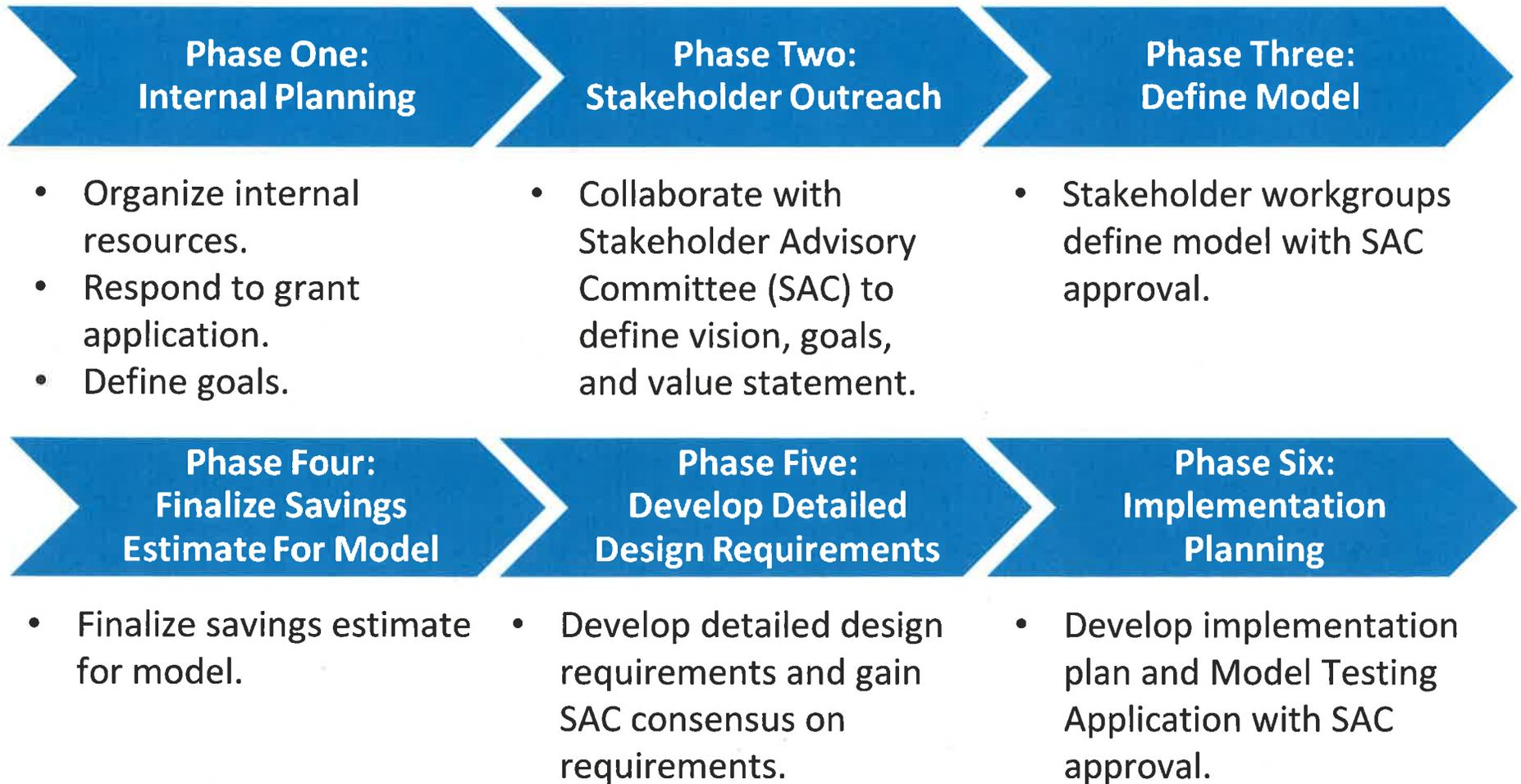
- Person/Family Centered – “from the person outward”
- The person’s needs are viewed holistically and met seamlessly
- Person/Families are Empowered to make informed and responsible choices
- Providers and payors collaborate to ensure access to high quality services
- Services are affordable and efficiently provided

•Desired Outcomes of the Model

- Improves quality of services
- Improves consumer outcomes
- Increases access to needed services
- Promotes holistic view of the consumer’s/family’s needs
- No waiting lists for services
- The new system is financially sustainable

Project Approach: Model Design

New Hampshire's State Health Care Innovation Plan Design Strategy consists of the following six phases.

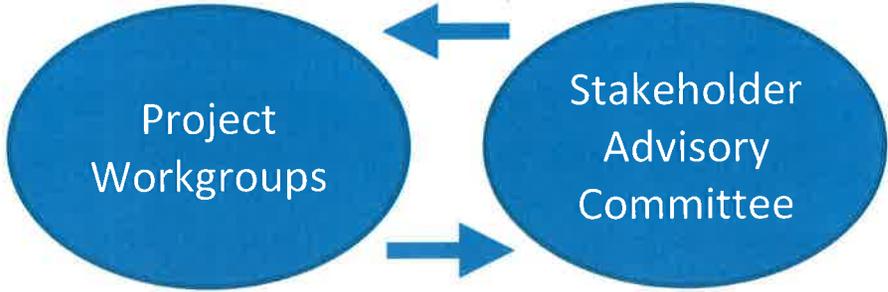


Project Timeline

New Hampshire’s State Health Care Innovation Plan Design Strategy will take place over a ten month period from September 2012 to June 2013.

Phase	Task	2012				2013						
		Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
Phase 1	Conduct Internal Planning	[Green arrow from Sept to Nov]										
Phase 2	Conduct Stakeholder Outreach		[Green arrow from Oct to Nov]									
Phase 3	Define Model				[Green arrow from Dec to Jan]							
Phase 4	Finalize Savings Estimate for Model				[Green arrow from Dec to Mar]							
Phase 5	Develop Detailed Design Requirements						[Green arrow from Feb to Mar]					
Phase 6	Conduct Implementation Planning							[Green arrow from Mar to Jun]				

Project Approach: Stakeholder Workgroups

<p>Project Workgroups</p>	<p>Each project workgroup will contain state and stakeholder representatives. Each workgroup will help define aspects of the model in the topic areas outlined to the right.</p>	<p>Delivery System Redesign</p>	<p>Payment Reform Design</p>	<p>Existing Initiatives</p>
<p>Stakeholder Advisory Committee</p>	<p>The Stakeholder Advisory Committee (SAC) will be responsible for validating the model design.</p>	 <pre> graph LR PW([Project Workgroups]) --> SAC([Stakeholder Advisory Committee]) SAC --> PW </pre>		
<p>State Team</p>	<p>The state team will participate on project workgroups and manage project organization and planning activities.</p>			

Delivery System Redesign Workgroup

- **Draft Charter**

- Identify aspects of the current system that are aligned with the Values and Mission statement
- Identify aspects of the current system that are not aligned with the Values and Mission statement
- Develop strategies to achieve better alignment that also protect current areas of alignment

Payment Reform Design Workgroup

- **Draft Charter**

- Identify current payment methodologies that are aligned with the Values and Mission statement
- Identify current payment methodologies that are not aligned with the Values and Mission statement
- Develop payment methodologies to achieve better alignment that also protect current areas of alignment

Existing Initiatives Workgroup

- **Draft Charter**
 - Review existing initiatives
 - Examine possible inter-relationships between the initiatives
 - Examine opportunities to better align existing initiatives with the Innovation Model's vision and goals
 - Examine opportunities to modify existing initiatives to better align with the Innovation's vision and goals

Regulatory and Legal Barriers Workgroup

- **Draft Charter**

- identify existing state regulations that are not in alignment with the Innovation Model's values and mission
- identify existing state statutes that are not in alignment with the Innovation Model's values and mission
- Develop recommendations for modification of existing regulations and statutes
- Develop recommendations for new regulations and or statutes to promote the Innovation Model

HIT/IT Workgroup

- **Draft Charter**

- Examine the current and developing state of use of HIT by LTSS and payers
- Develop a strategy to leverage HIT to promote the Model's vision and mission
- Identify gaps or barriers to leveraging HIT
- Develop recommendations to address gaps and barriers

Other Barriers and Challenges Workgroup

- **Draft Charter**
 - What are we missing in other 5 workgroups that need to be addressed?
 - Do we need a quality workgroup separate from the payment reform strategy?
 - Should we have a workforce workgroup?
 - Others????

Present State Review

Division for Children, Youth and Families (DCYF)

Medicaid Rehabilitation Option
Services

DCYF Rehabilitation Option Services Eligible Population

- Children served by DCYF through a court order petition for abuse, neglect, CHINS, or delinquency.
- Children may be removed from their homes and placed in out-of-home care or may remain in their own homes as DCYF provides services to address the family/child concern that brought the child and family into DCYF.

DCYF Rehabilitation Services

- **Child Health Support**
 - Families who need therapeutic intervention to avert future neglect, abuse, delinquency, status offenses, emotional disturbances, and out-of-home placement of a child; and foster families who require assistance in order to preserve the placement.
- **Home Based Therapeutic Service**
 - On-call 24-hour availability to families; family and individual counseling with family members and persons in their immediate support system to develop or maintain family growth and assistance necessary for independent family functioning.

DCYF Rehabilitation Services

- Intensive Home and Community Services –
 - Adolescent Community Therapeutic Service
 - Provided to youth who are exhibiting acting-out behaviors in the home, school or community’ and require strength based counseling and support that include multiple contacts with the child and family and school to monitor behavior.
 - Individually Designed Therapeutic Services Daily Rate
 - Shall consist of multiple, specialized services to meet the unique needs of the child in the community.
 - ISO & Day Treatment In Home Daily Rate
 - Agencies promote family self-sufficiency and to connect families to supports in the community.

DCYF Rehabilitation Services

- Placement Services – the treatment portion of the daily rate (therapy, counseling) provided in group homes and residential facilities
 - Private Non-medical Institution
 - Individual Service Option (Treatment level foster care)
 - Child Specific Specific Daily Rate
 - Agency Specific Daily Rate

Example of DCYF Providers

- Casey Family Services
 - ISO In Home, Home Based Therapeutic, ISO Out of Home, Child Health Support
- Child and Family Services
 - Residential Group Home, ISO In Home, Home Based Therapeutic, Child Health Support, Adolescent Community Therapeutic, Therapeutic Day Treatment, ISO Out of Home
- Easter Seals of NH
 - Residential Group Home, ISO In Home, Home Based Therapeutic, Child Health Support, Adolescent Community Therapeutic, ISO Out of Home

Example of DCYF Providers

- Fulcrum Behavioral Consultants
 - Adolescent Community Therapeutic, Home Based Therapeutic
- Life Share Management Group
 - Therapeutic Day Treatment, ISO In Home, Home Based Therapeutic, Child Health Support, ISO Out of Home
- Mount Prospect Academy
 - Residential Group Home, ISO In Home, Home Based Therapeutic

Example of DCYF Providers

- Nashua Children's Home
 - Residential Group Home, Home Based Therapeutic
- NFI North
 - ISO In Home, Home Based Therapeutic, ISO Out of Home
- And many more

Care Plan/Treatment Plan

- Providers of DCYF Rehabilitation Option Services are required to develop a treatment plan in conjunction with the Child Protection Services Worker (CPSW) or the Juvenile Justice Probation Parole Officer (JPPO), family and Youth.
- The DCYF CPSW/JPPO are responsible for developing the case plan for the child and family.

Authorization for Services

- The CPSW/JPPOs recommend services and/or placements to the court.
- The court orders services for the child and family.
- The CPSW/JPPO authorizes the services ordered by the court by requesting that the service authorization be entered into MMIS by the DCYF Fiscal Specialist.
- All DCYF Rehabilitation Services are only available to children and families involved with DCYF and only DCYF Fiscal Specialists or Provider Relations Staff enter prior authorization for services into MMIS.

BBH Provider System: Overview

State is divided up into **10** catchment areas and services are provided through:

- a) **10** Community Mental Health Centers
 - Independent, non-profits
- b) **2** Community Mental Health Providers
 - Housing for Individuals with Mental Illness
- c) **Peer Support Agencies** in all 10 regions of the State, some regions have multiple sites.
- d) **1** Family Mutual Support Organization (NAMI NH)

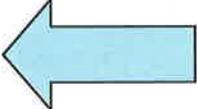
Broad Array of Services Provided

- **Evidence Based Practices (statewide)**
 - Illness Management and Recovery (IMR)
 - Supported Employment (EBSE)
 - Trauma Focused Cognitive Behavioral Therapy
 - Assertive Community Treatment Teams (ACT)
 - **Functional Support Services**
- Targeted Case Management
- Supported Housing- Focus on serving individuals in their own homes and apartments
- Individual and Group Psychotherapy Services
- Intensive Partial Hospital
- Psychiatry and Medication Services
- 24-Hour Community Residential Programs
- Acute Psychiatric Residential Treatment Program (APRTP)- Crisis Beds

Community Mental Health Centers: Population Served

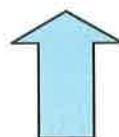
- In SFY 2012, a total of **49,561** individuals were served through the community mental health system.

- **10,664** were adults with a severe mental illness (SMI/SPMI)

20,267 

- **9,603** were children with serious emotional disturbance (SED)

- We are seeing an increase from the previous year in the number of individuals with SMI/SED served in the system.



5.2% Increase

- **Of the 49,561 individuals seen: 21,000 have Medicaid.**

Authorization for Services

- The Community Mental Health Center Treatment Team, with a Psychiatrist overseeing the plan of care developed with the team and the consumer/family develop an annual treatment plan.
- The treatment plan specifies the types of services to be provided, who will provide them, and the amount, frequency and duration of the services.
- Most services are not subject to any annual limits or need for a prior authorization.

Services with limitations

- For Adults only:
 - Functional Support Services in the community are limited to 2 ½ hours per day. The CMHC can request authorization to exceed this daily limit through the Bureau of Behavioral Health based on the clinical needs of the client.
 - Individuals who are eligible for community mental health services in the “Low Utilizer” category, have an annual limit of \$4,000 per year in community mental health services. There is a waiver process to have the individual determined eligible in the SMI or SPMI category based on the clinical needs of the client and BBH approval.
- Adults and Children who are not determined eligible for community mental health services, are subject to an annual limit of \$1,800 per year in services (ex. Psychotherapy visits).

CFI Overview



CFI Eligibility

- To be eligible for CFI services, an applicant must meet:
 - The target population criteria approved by the Centers for Medicare and Medicaid Services (CMS);
 - NH Medicaid financial eligibility requirements, as determined by the newly created Member Services Division (formerly the Division of Family Assistance); and
 - Clinical eligibility standards as defined in RSA 151-E:3 and He-E 801.

CFI Eligibility (cont)

- CFI participants are Medicaid-eligible individuals who are age 18 years or older and require 24-hour care for one or more of the following purposes, as determined by a registered nurse :
 - Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services;
 - Restorative nursing or rehabilitative care with patient-specific goals;
 - Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or
 - Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence.
- Another component of eligibility is that the person must need waiver services to avoid institutionalization. Therefore, participants must require and receive at least one CFI service at least monthly.

Clinical Eligibility Determination

- Clinical eligibility is determined by the Medical Eligibility Assessment (MEA) instrument for CFI and the Minimum Data Set (MDS) for residents of nursing facilities.
- All MEAs are completed by nurses trained by the BEAS to complete the instrument.
- Completed MEAs are electronically submitted to BEAS where eligibility determinations are made by nurses.

Best Practice

- Included in the data collected to determine clinical eligibility are specific questions designed to assist in the recognition of:
 - Cognitive disorders;
 - Depression;
 - Substance abuse; and
 - Risk.
- Data collected from the MEA provides current information that is used to drive the development of a comprehensive long term care service plan.

CFI Services and Providers

- About 300 providers are enrolled in the NH Medicaid Program to help CFI participants remain as independent as possible in the community.
- Covered services include the following:
 - Adult medical day services;
 - Environmental accessibility adaptations;
 - Home-delivered meals services;
 - Home health aide services;
 - Homemaker services;
 - Non-medical transportation services;
 - Personal care services;
 - Personal emergency response system services;
 - Residential care service;
 - Respite services;
 - Skilled nursing services;
 - Supportive housing services.

CFI Cost Controls & Expenditures

- RSA 151-E: 11 contains significant cost controls for the program, as follows:
 - The average annual costs in the aggregate for home care and mid-level care shall not exceed 50% and 60%, respectively, of the average annual cost for nursing facility services.
 - If the costs of community based care for a participant or applicant are expected to exceed 80% of the average annual cost for the provision of services to a person in a nursing facility, prior approval from the Commissioner's Office is required.
- Total expenditures SFY2012: \$50,933,790
- Total unduplicated CFI participants: 3,722 (2,866/mo ave)
- Ave/month cost for home care per participant: \$1,464 (27% of NF costs)
- Ave/month cost for mid-level care per participant: \$1,640 (30%)
- Average monthly cost per NF resident: \$5,454

CFI Program Management

- CMS places significant emphasis on program oversight and quality assurance. They have established six assurance domains to address each appendix of the waiver document.
 1. Level of Care
 2. Service Plan
 3. Provider Qualifications
 4. Health and Welfare
 5. Financial Accountability
 6. Administrative Authority
- For each assurance, BEAS has developed, and CMS has approved, multiple performance measures for program monitoring.

CFI Participant Experience

- Every two years, BEAS has conducted a Participant Experience Survey (PES) to hear the participant's perspective.
- In 2010, 95% of participants surveyed were satisfied or very satisfied with the services they were receiving.
- The entire report of the 2010 PES survey can be found on the DHHS website at:
<http://www.dhhs.nh.gov/dcbcs/beas/documents/survey2010.pdf>

Questions??



NH DHHS

DCBCS

Bureau of Developmental Services



Populations Served

- **Individuals with Developmental Disabilities (DD)**
 - Such as autism, intellectual disability, cerebral palsy, learning disability
- **Individuals with Acquired Brain Disorders (ABD)**
 - Such as traumatic brain injury, Huntington's disease
- **Children with Chronic Health Conditions**
 - Such as asthma, diabetes, heart disease
- **12,000 to 13,000 people are served**
- **The great majority of the individuals who are served through the BDS system have lifelong disabilities and require long-term care services**



Service System

- **Provides community-based services only**
 - No institution since 1991
- **Offers services through a regional structure**
 - 10 non-profit designated organizations called **Area Agencies** (AA) function as lead agencies
 - Based on RSA 171-A
 - BDS contracts with AAs
 - Area agencies also use subcontract agencies to provide services

NH DHHS DCBCS Bureau of Developmental Services AREA AGENCIES

Key Personnel

- Service Coordination Supervisor
- BDS Liaison

Lakes Region Community Svcs (III)

- Laurie Vachon lauriev@lrcsc.org
- Jude Schultz jschultz@dhhs.state.nh.us

Pathways of the River Valley (II)

- Cory Shomphe cshomphe@pathwaysnh.org
- Todd Ringelstein tringelstein@dhhs.state.nh.us

Community Bridges (IV)

- Barbara Drotos bdrotos@communitybridgesnh.org
- Jude Schultz jschultz@dhhs.state.nh.us

Monadnock Developmental Svcs (V)

- Alison Scalia Alison@mds-nh.org
- Ken Lindberg klindberg@dhhs.state.nh.us

Gateways Community Services (VI)

- Kristen Lepannen klepannen@gatewayscs.org
- Kaarla Weston kweston@dhhs.state.nh.us

Northern Human Services (I)

- Liz Charles lcharles@northernhs.org
- Todd Ringelstein tringelstein@dhhs.state.nh.us

Community Partners (IX)

- Pamela Dushan pdushan@bhdssc.org
- Denise Sleeper denise.sleeper@dhhs.state.nh.us

One Sky Community Svcs (VIII)

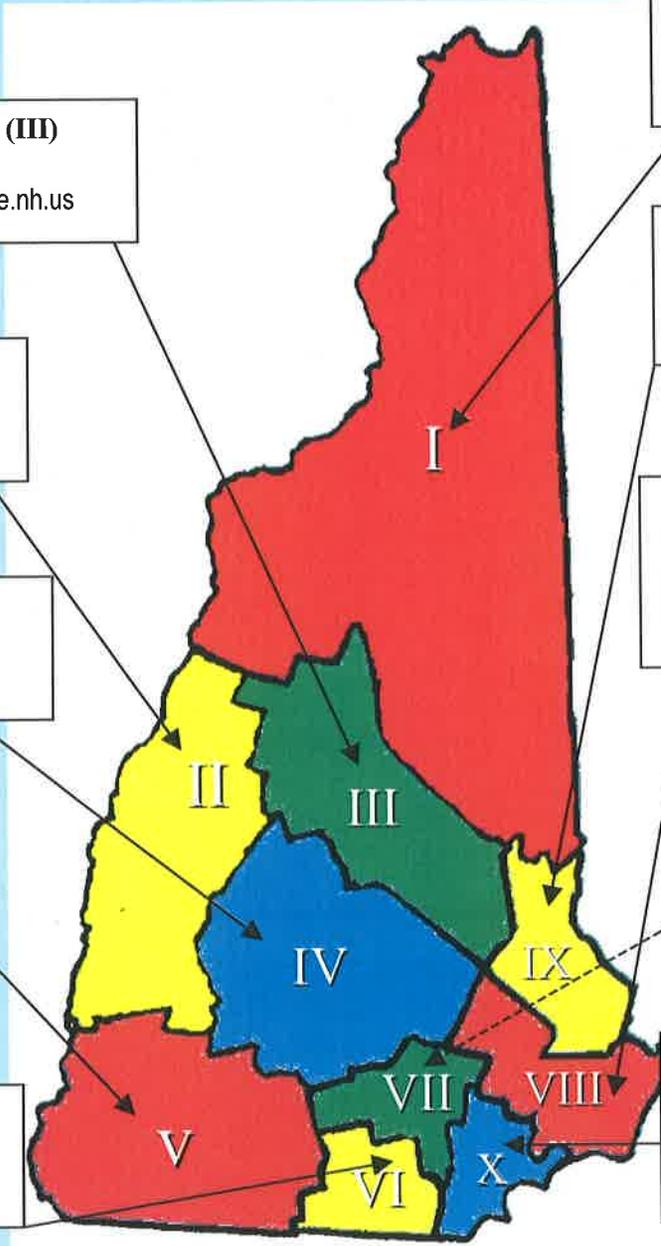
- Karen McLaughlin
K.McLaughlin@oneskyservices.org
- Darlene Ferguson dferguson@dhhs.state.nh.us

Moore Center Svcs (VII)

- Maureen Rose-Julian maureen.rose-julian@moorecenter.org
- Kaarla Weston kweston@dhhs.state.nh.us

Community Crossroads (X)

- Kelly Judson
kjudson@communitycrossroadsnh.org
- Ken Lindberg klindberg@dhhs.state.nh.us





Fundamental Elements of the System

- **Person-centered-planning**
 - Focuses on each individual's needs, interests, preferences and challenges
 - Informed by the results of the assessment tool called "**Support Intensity Scale**" (SIS)
 - Leads to the creation of an "**Individual Service Agreement**" (ISA) for each individual
 - Intended to promote the individual's personal development and quality of life
 - In a manner that is determined by the individual
 - Provide opportunities for the individual to exercise personal choice, independence, and autonomy
 - Within the bounds of reasonable risks
 - Meet the individual's needs in personal care, employment, adult education and socialization



Fundamental Elements of the System

- **Individual Budgets**

- Created for each person based on the services identified in the ISA and availability of funds
- Individual differences in capacities and needs can mean that costs for services will vary from person to person
- BDS reviews and approves proposed budgets
 - Revised if there is a change in the individual's condition
- Results in an individual funding allocation for each person
- The individualized budgets are intended to create a financial approach that supports the provision of individualized services
- AAs are expected to help the individual/family access generic/natural supports available locally before using system funds



Fundamental Elements of the System

Medicaid Waivers

- **Medicaid is used extensively to fund services**
 - About 97% of the total funds comes from Medicaid
- **BDS operates three 1915(c) Waivers as funding sources for long-term care services:**
 - 1. Developmental Disabilities Waiver**
 - All ages
 - Enrollment of ~ 4,200
 - 2. Acquired Brain Disorders Waiver**
 - Age 22 or older
 - Enrollment of ~ 195
 - 3. In-Home Supports Waiver**
 - Ages birth to 21
 - Enrollment of ~ 340
- The system uses Waiver funds to help individuals to live, work, socialize, and fully engage in their communities



Waiver Services

- Residential/Personal Care
 - Day Habilitation Services
 - Independent Living
 - Service Coordination
 - Assistive Technology
 - Consumer Directed Services
 - **Supported Employment ***
 - **Respite ***
 - **Crisis Response Services ***
 - **Home/Environmental and Vehicle Modifications ***
 - **Specialty Services ***
 - BDS has developed unique service definitions that have been approved by CMS
- * Services not typically funded under the State Plan**



Waiver Services

- **Waiver eligibility requirements are based on an institutional framework:**
 - Individuals must meet **Institutional Level of Care (LOC)** to be eligible for Home and Community-Based Waiver Services
 - SNF for ABD Waiver, ICF for DD and IHS Waivers
 - Individuals must be determined eligible for Waiver services beyond being eligible for Medicaid
 - LOC must be re-determined annually
 - Without regard to the nature of the disability
 - A portion of the system's resources are used for this cumbersome determination process



Waiver Services

- **BDS prior authorizes (PA) services for each individual**
 - PAs are issued for one year only and must be renewed yearly
- **Each BDS Waiver program has a cap for enrollment and cost approved by CMS**
 - Waiver must be amended to exceed these caps
- **BDS Waivers demonstrate “cost neutrality”**
 - In aggregate Waiver costs cannot be more than the cost of services in institutional settings
- **Reimbursement/budget caps**
 - For example the IHS waiver has a cap of \$30K at the individual level



Fundamental Elements of the System

- **Consumer Choice and Control** is a guiding principle
 - BDS rules empower individuals/families/guardians to exercise choice and control over all aspects of their services, including:
 - Planning
 - Recruitment of staff/providers
 - Location of services
 - Under **Consumer Directed Services** this involvement also includes making decisions regarding how the allocated funds would be used
 - Funds are used to purchase services and items related to individual's disability
 - Individual/family/guardian can make line item adjustments within the bottom-line without a BDS review
 - All BDS Waivers offer the consumer directed services option



Fundamental Elements of the System

- **Community Participation** is an area of focus and is considered for all individuals
 - Emphasize **employment** services and outcomes
 - Over 1,200 people have jobs
 - Volunteerism opportunities
 - About 800 people volunteer in their local communities
- **Lower Cost Residential Service Models**
 - Using home-provider models (vs. staffed residence) for residential arrangements
 - Many adults continue to live at home with their families while receiving services
 - 8 out of 10 people receiving residential supports live in family (natural or provider) homes



Fundamental Elements of the System

Quality Reviews

- **National Core Indicators Project:**
 - Interviews with individuals
 - Family surveys
 - Identifies systemic issues, such as health disparities:
 - Only 13% of people age 50/older had a colonoscopy screening
 - Only 31% of men over 50 had a PSA Test within the past year
- **Quality Council:**
 - An advisory body comprised of individuals, family members, area agencies, provider agencies, advocacy organizations
 - Reviews and provides input/feedback regarding outcome data, information, regulations, policy



Family Involvement At Individual Level

- Families have typically been the most committed, enduring, and critical source of support for NH's citizens with I/DD
- **Two of the most important benefits the system has provided to individuals with a disability have been to:**
 - **Help maintain their relationships with their families**
 - **Assist the families in supporting the individual**
- One of the most crucial and indispensable elements of nearly all successful service arrangements in NH has been the extensive and continued family involvement in the lives of individuals
 - Supported and encouraged by the system



Family Involvement At Systemic Level

- Families have been the most influential stakeholder group in shaping NH's services system for individuals with DD or ABD
 - Through their involvement in regional Boards of Directors and Family Support Advisory Councils
- **Nearly all systemic progress and improvements in NH's regional service system has been prompted, facilitated, and achieved through family involvement, input, requests and efforts**



Regional Orientation

- Easier for agencies to reach out to and maintain relationships with consumers
 - **“Smaller service universe/infrastructure” for consumers to navigate through**
 - Designated agency staff (e.g., service coordinators) as a local contact person to:
 - Advocate for the individual/family
 - Facilitate outcomes
 - Oversee services
- AAs and providers get to know people’s needs
- Regional orientation has maximized opportunities for collaboration among local health, education, and social service organizations to:
 - Improve outcomes for individuals and their families



Local Connections and Relationships

- Families are better able to establish relationships with each other within the region
 - Parent-to-parent connection as a source of help for families
- Families are more willing to get involved in a regional/smaller scale system as members of:
 - AA Board Of Directors
 - Regional Family Support Advisory Councils



Consideration For LTC Redesign

- Make room for, respect, and support regional arrangements, relationships and collaborations, as they have fostered the development of:
 - More effective relationships between consumers and provider organizations
 - Community resources
 - New strategies and explorations
 - Long-term advocacy and commitment to supporting vulnerable populations

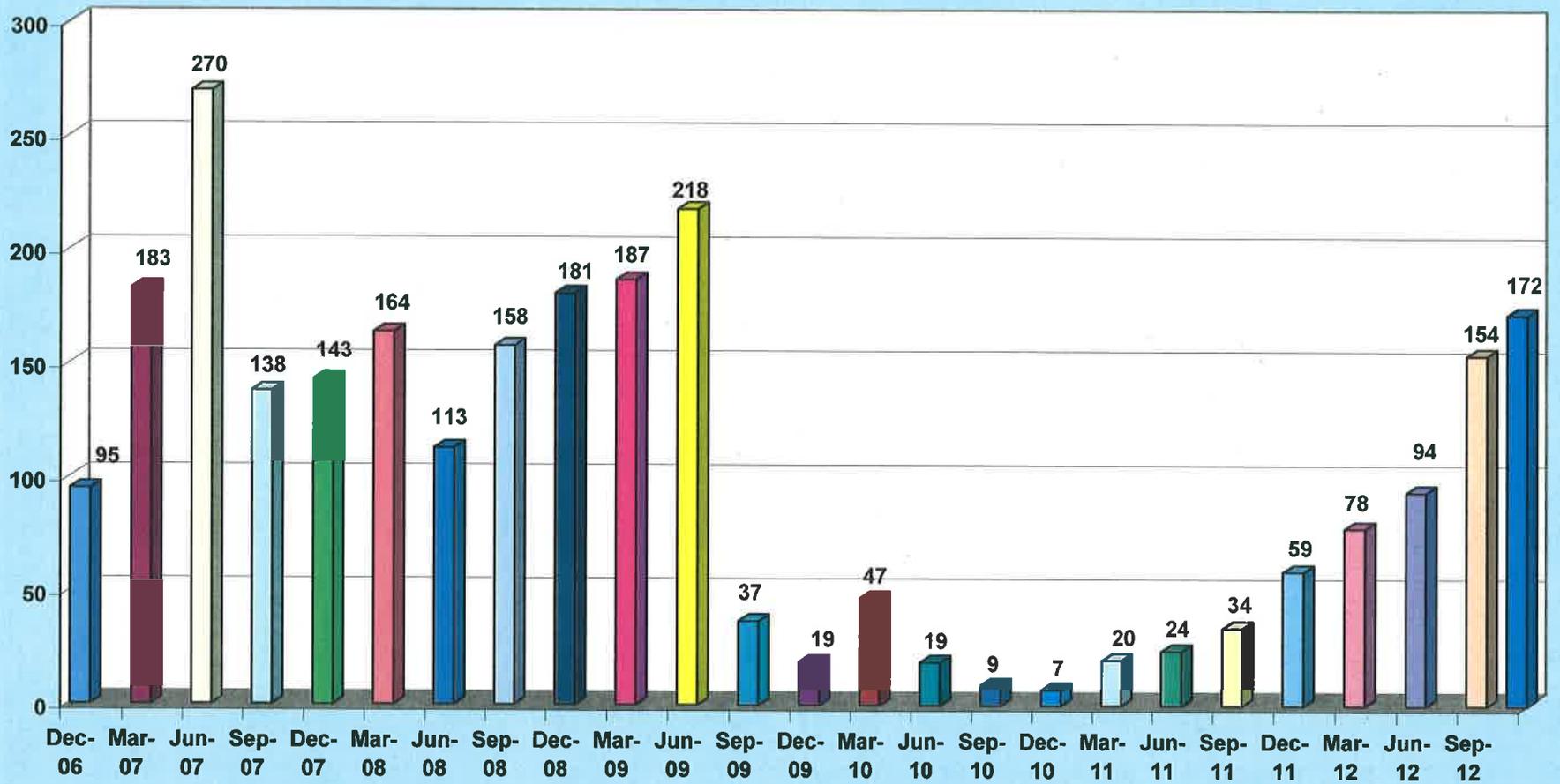


Systemic Challenges

- **Wait Lists** for services funded under the Waivers
 - The system has a very long history of having Wait Lists
- **Increased demand for services:**
 - More students with I/DD aging out of the education system
 - Significant rise in the prevalence of Autism Spectrum Disorders
 - “Baby boomer” generation of parents now requesting residential services
 - Individuals with disabilities living longer and requiring additional supports as they age and experience medical issues



Bureau Of Developmental Services DD Wait List Number Of People





Systemic Challenges

- The funding requirements regarding Wait Lists have prevented allocation of new funds to other need areas
- There are gaps in the system concerning clinical capacity and resources regarding
 - Psychiatric needs
 - Behavioral needs
 - Medical needs
 - Crisis response needs
- It is important that recent initiatives (START, HRST) that have been launched by the system be sustained and supported in the future



Systemic Challenges

- NH's regional system has had difficulties in recruiting and retaining direct service staff and providers
 - Wages offered are typically very modest
 - A considerable number of positions are part time and/or offer no benefits
- Challenges around staffing impacts the system's capacity to allow staff and providers to attend training sessions
 - No substitute staff available



Unique Challenge

- Some of the individuals and families do not see NH's regional system as "broken":
 - They tend to be skeptical of the idea that system changes will lead to improvements for them personally
 - A number of them seem to fear that their services may be impacted adversely
 - Some worry that the new system may end up reflecting systemic interests and goals rather than individual and family needs and what is important to consumers

Wrap-Up and Next Steps